OneCare Vermont

2023

Budget Presentation to

Green Mountain Care Board

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Budget Section 1

ACO Budget Executive Summary

The 2023 budget brings *value* to Vermont's health care providers:

Progressively increasing provider network accountability to improve quality and outcomes, while reducing administrative burden

~$30M payments directly to health care providers to support population health improvements during a fragile economy; more than 70% goes directly to primary care

Increasing coordination by engaging continuum of care and leveraging federal funding for Blueprint and SASH

Promoting innovation in primary care payment models that advance value-based care; CPR participation has tripled since 2018

The 2023 budget deepens *engagement* in value-based care:

Doubling risk/rewards for providers $16.2M to $36.5M

$1.4B of eligible health care costs in value-based arrangements

5,000+ providers statewide and ~80% of eligible primary care; growth in Medicare and CPR

Admin rate 1.1% of total cost of care (national average of 2%)*

**MedPac. (2018). Medicare accountable care organization models: Recent performance and long-term issues Retrieved from https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun18_ch8_medpacreport_sec.pdf*

OneCare's Core Capabilities

Network Performance Management

Data and Analytics

Payment Reform

OneCare Core Capability: Network Performance Management

Care Model

- Population health committees restructured and revitalized to provide statewide voice
- Advancing Population Health Model further deepens engagement in care coordination and prevention efforts
- Population health payments simplified and aligned with individual and ACO accountabilities

Network Contracting

- 5,128 providers - 100% retention for 2023
  - 14 hospitals | 82% of primary care | Growth in Medicare and CPR participation
- ~297,000 people attributed and ACO accountabilities

Outcomes

- Low-cost Medicare ACO when compared to national cohort of ACOs
- In 2021, OneCare earned $5.5M in network-wide shared savings, $2.5M being distributed to primary care providers through accountability pool matching
- In 2021, exceeded most clinical measurement expectations on priority areas

OneCare Core Capability: Data and Analytics

Reporting and Resources

New primary care, quality measurement, and health disparity report cards

Medicare benchmarking tool to identify strengths and opportunities

Analytics platform procured to enhance future ACO activities

Engagement Outcomes

Enhanced health service area (HSA) accountability and reporting structure

- All communities actively engaged and 90% of Vermont hospital participants using additional self service tools to drive improvement

OneCare Core Capability: Payment Reform

Fixed Payments

- Expand Medicaid fixed payment for hospitals with DVHA
- New Medicaid fixed payments for ambulatory surgery center with DVHA
- Medicare to continue to reconcile payments until 2025
- Commercial payers not expected to expand until 2024

OneCare Core Capability: Payment Reform, *continued*

Comprehensive Primary Care (CPR)

- Continuous year over year growth in program participation
  - Six sites in 2018 to **19 sites** in 2023
- Greatest satisfaction with fixed stable payments
- Predictable per member per month (PMPM) payments plus enhanced incentives for advanced primary care services
  - In 2022, earned on average 23% more compared to fee for service
  - Direct engagement with practices to further inform and evolve program design

OneCare Core Capability: Payment Reform, *continued*

Supporting Primary Care in Population Health Innovations

Year	Actual PHM Payments	Primary Care as % of total	Primary Care TINS
2018	$21.2M	67%	37
2019	$31.8M	72%	49
2020	$30.3M	74%	57
2021	$26.1M	76%	53
2022	$29.0M	79%	53
Total →	$138.4M		

Diversity, Equity, and Inclusion

DEI: Governance

- Created a committee focused on health equity
- Engaged boards and committees in DEI training and committed to regular discussions at meetings
- Developed recruitment strategies for more inclusive onboarding processes

DEI: Network

- Developed and engaging with participants on DEI scorecard data
- Incorporated social determinant data into program designs

DEI: Employees

- Leveraged external survey to understand opportunities for improvement as an organization
- Providing ongoing training and education

Budget Section 3

ACO Payer Contracts

Value-Based Care Programs

Budget includes continuation of all payer programs offered in 2022

Medicare

- Risk corridor increased to 3%
- Trend rate budgeted per CMS forecast

Medicaid

- Risk corridor increased to 3% for the Traditional Cohort; 2% for Expanded Cohort
- Collaborating on a fixed payment expansion initiative

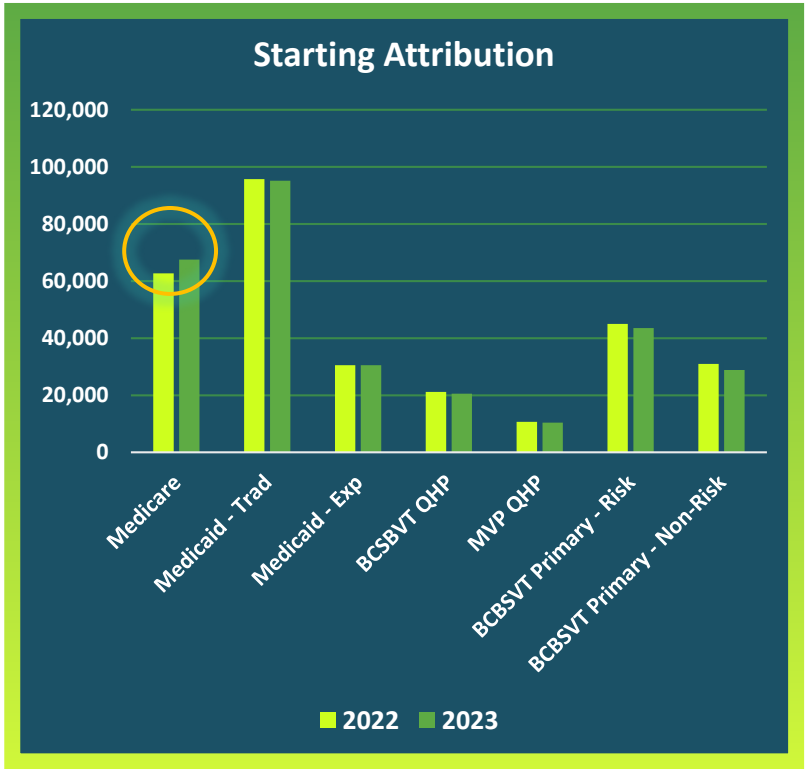
Commercial

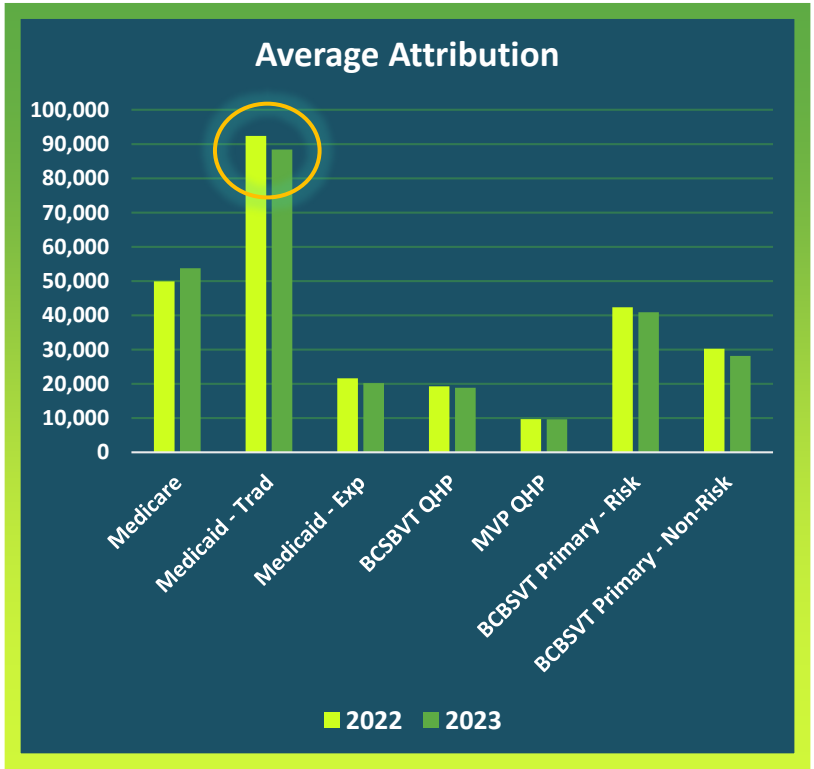
- Budgeted to increase risk sharing arrangements
- Trend rates budgeted to follow approved insurance rate and provider increases

Attribution by Program

Budget estimates 297k lives; 268k expected to qualify for scale

- Medicare attribution budgeted to increase due to St. Johnsbury participation
- Expecting Medicaid redetermination to resume during 2023
  - Does not affect starting attribution, but will affect attrition throughout the year
- Anticipate Medicare Advantage growth to continue to partially offset increases otherwise expected from St. Johnsbury participation and an aging population

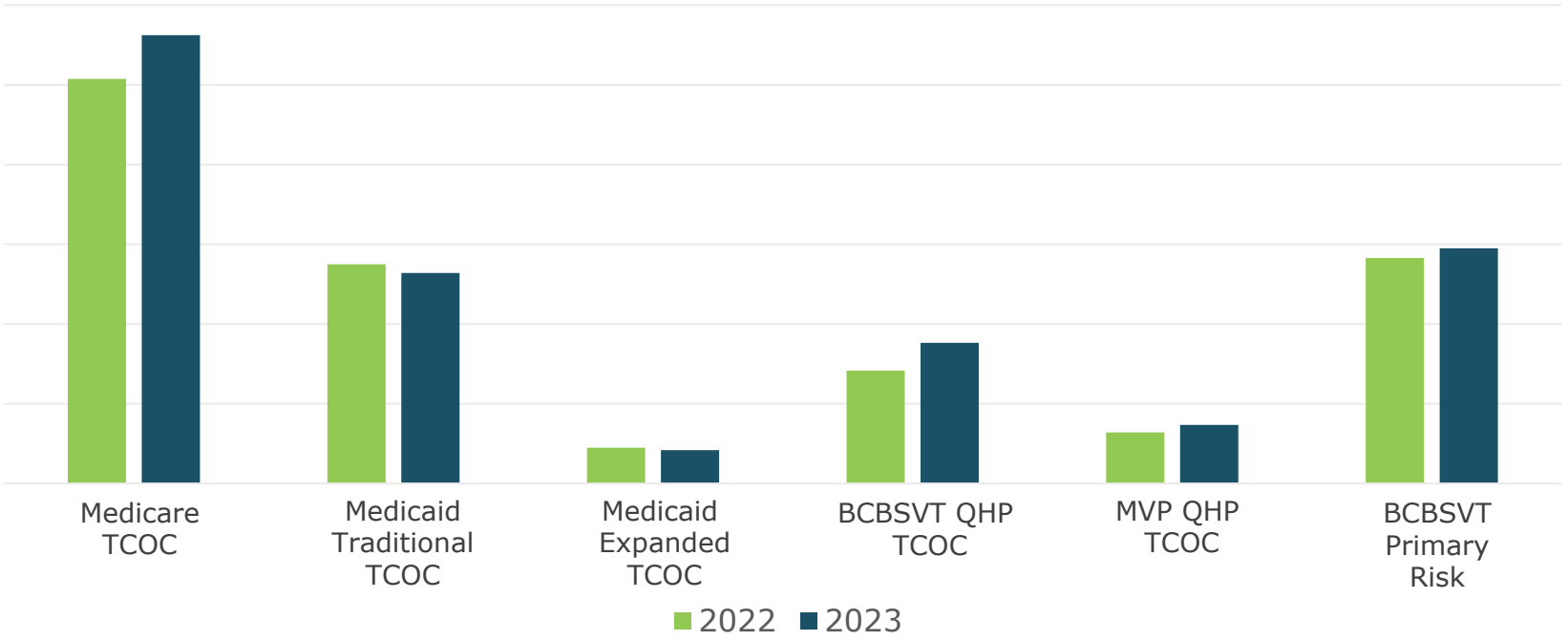




Budget Section 4

Total Cost of Care

Estimated Health Care Accountability



$1.4B of Health Care Costs in Value-Based Contracts

- Estimated changes to accountability targets stem from attribution changes, insurance rate increases, and other payer reimbursement modifications
- Medicare increase driven by the addition of St. Johnsbury
- Medicaid TCOC expected to go down due to redetermination

Program Trend Rates

Budgeted trend rates based upon expected contractual terms and independent data analysis

Medicare

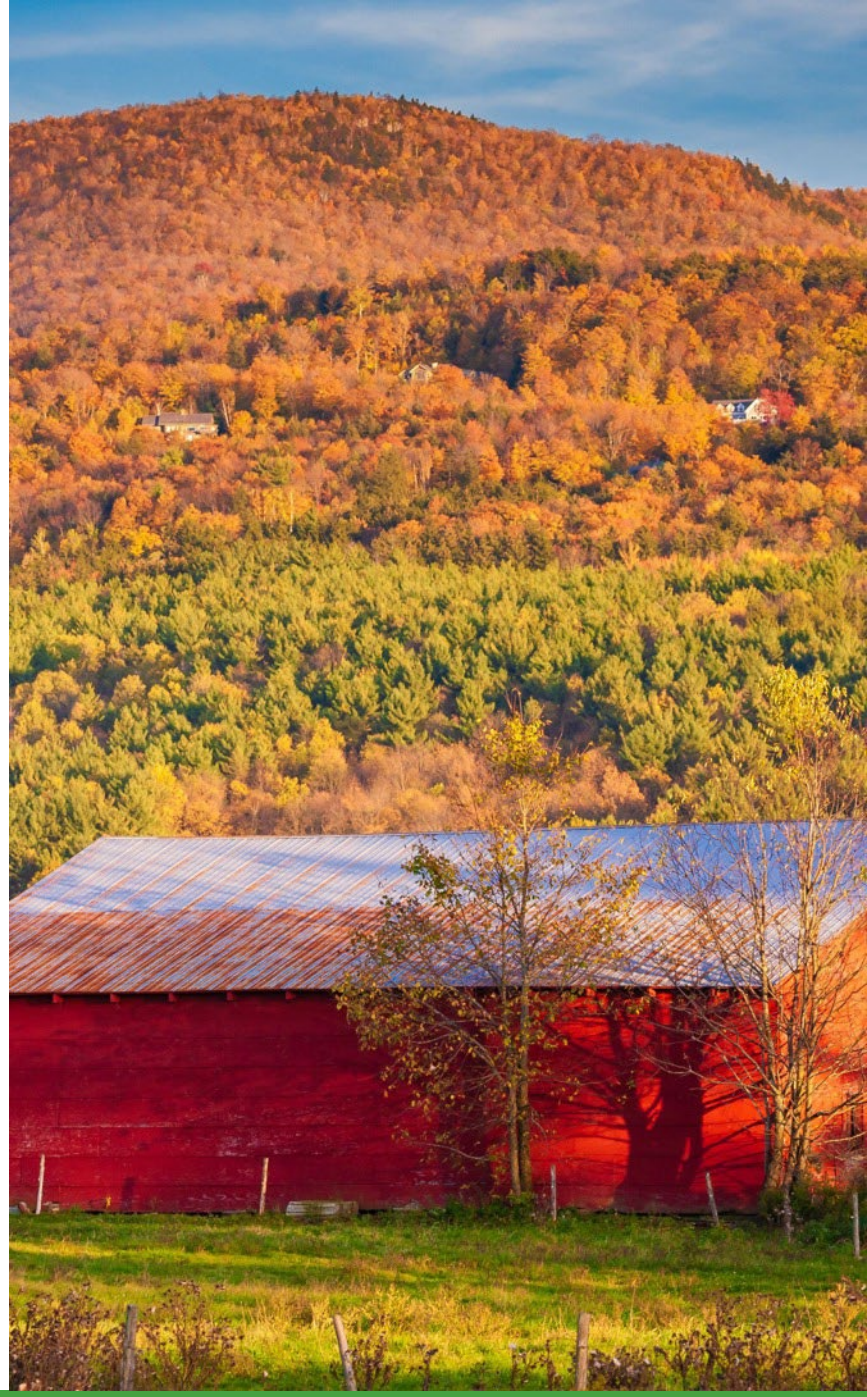
- 5.2% trend budgeted per Medicare United States Per Capita Cost (USPCC) forecast

Medicaid

- Based on analysis of prior year trends generated through actuarial rate development and claims data

Commercial Programs

- Informed by approved rate filings and incorporated trends



Budget Section 5

ACO Network Programs and Risk Arrangement Policies

Payment Reform Offerings

The submitted budget includes continuation of the current fixed payment arrangements

- Medicare: Reconciled to FFS
- Medicaid: Unreconciled
- Commercial: Reconciled to FFS

Significant energy was invested in commercial fixed payment expansion

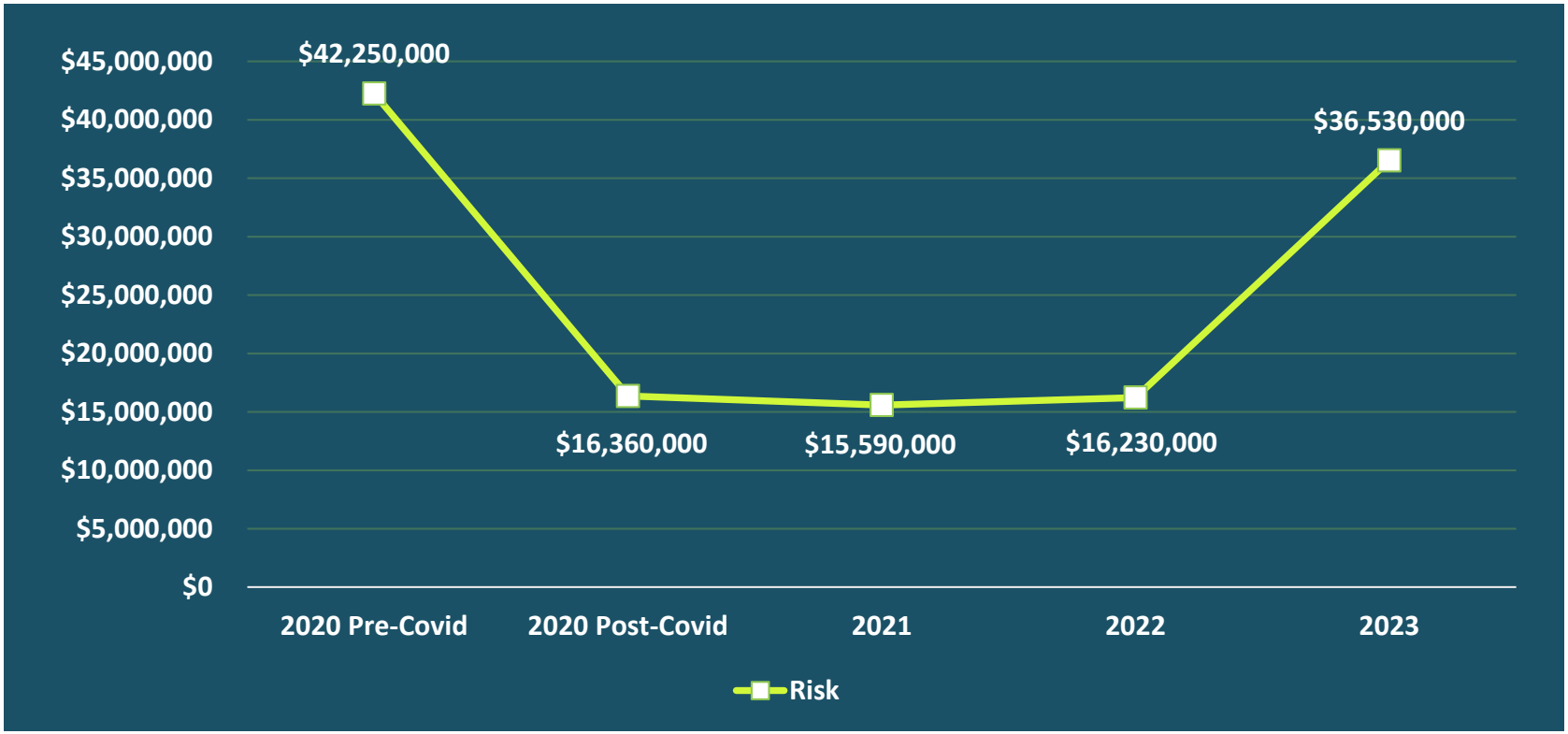
- Technical limitations, low marketable value, and low risk tolerance for variation from fee for service (FFS) are understood to be the most immediate barriers
- OneCare aggressively pursued an offering for CPR practices

OneCare and Medicaid (DVHA) are in active development of a fixed payment expansion initiative

- Aims to increase the percentage of Medicaid reimbursement covered by the fixed payment
- Initial focus on hospital care to lives not currently attributed to OneCare
  - Potential to expand covered services in future year

Risk/Reward Levels

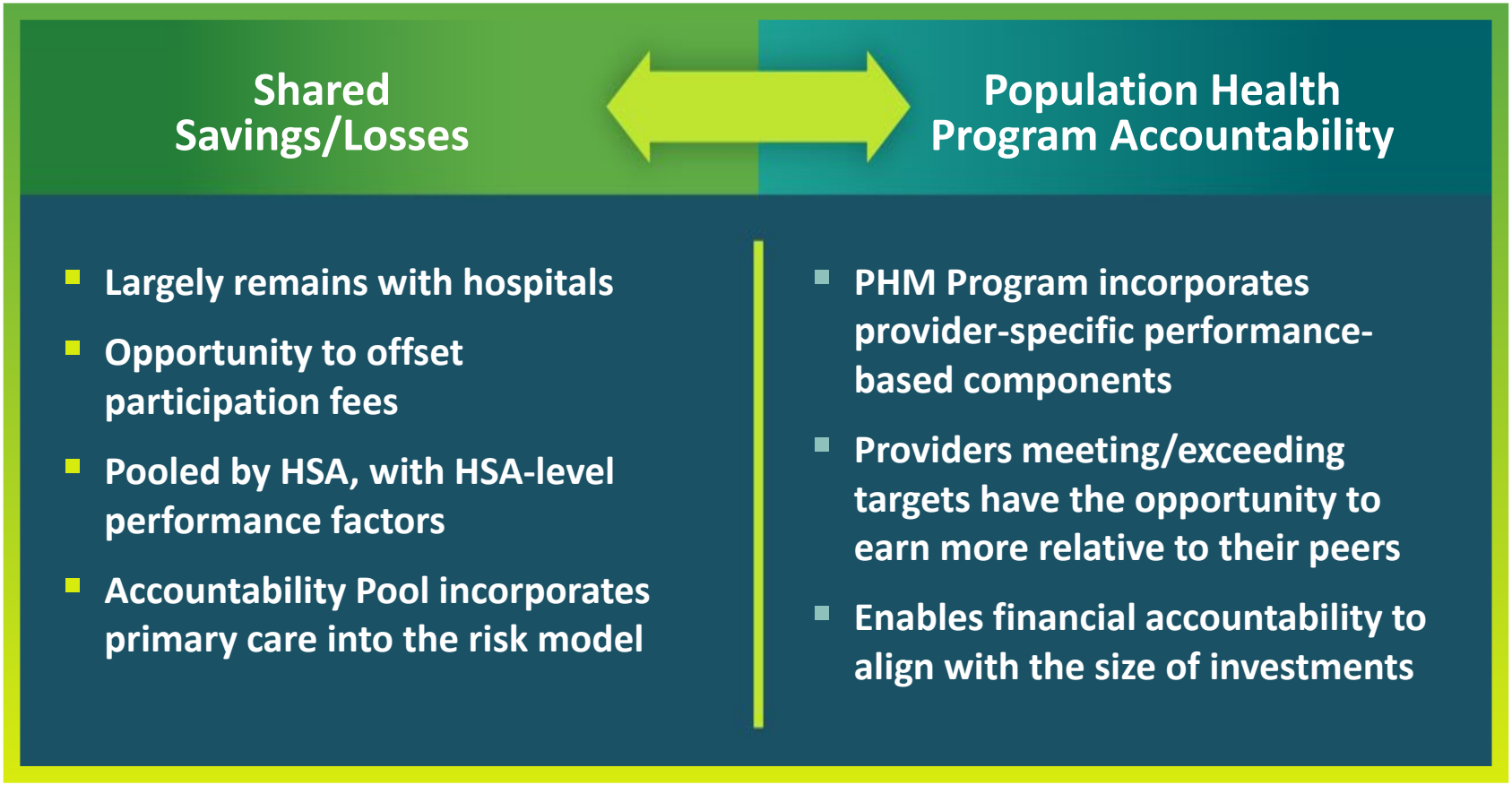
- Total cost of care forecasts are prepared for the purpose of estimating risk/reward opportunity
- Budget model incorporates significant increase to total risk/reward potential for providers
  - Nears pre-pandemic levels



** Figures approximate the budgeted/estimated risk levels entering the performance year. The figures do not factor in COVID-related adjustments such as proration for the duration of the public health emergency.*

Approach to Accountability

Working together, these two elements spread accountability down to the individual practice level without overloading community providers with untenable risk.



Risk Management Notes

- Accountability Pool components will apply universally
  - Accountability Pool contributions applied only to Medicare and Medicaid through the Public Health Emergency
  - Deferral option remains
- OneCare is offering a risk mitigation arrangement for NVRH as the St. Johnsbury HSA enters the Medicare program for the first time
  - Limit the St. Johnsbury HSA to a 1% Medicare risk corridor
  - OneCare receives savings or owes losses beyond the 1% limit as well as any Blueprint obligations
  - Reserves used to fund any OneCare obligations
- Unique accommodations to grow CPR program
- No reinsurance arrangement budgeted
- Medicare financial guarantee planned to be facilitated through the same line of credit arrangement

Budget Section 6

ACO Budget

$29.9M
in population health management program investments

$15.2M
in OneCare shared infrastructure

Overview: $45.1M ACO Budget

Balanced Budget

- No profit or loss
- No additional contributions to OneCare reserves

Key Elements

- Transition to the new PHM Program financial model
- Work reconfiguration
  - Reduced office space to align with primarily remote work model
  - Redesign of analytics support

Revenue Highlights

Landscape

- Budget includes consistent reform investments through payer contracts
  - Revenue levels float with attribution
- Potential incorporation of $2M in Medicaid VBIF funding
  - Currently outside of OneCare profit and loss statement; paid directly to providers by Medicaid
  - May remain with Medicaid for direct provider payments
- $205k (1%) increase in hospital participation fees

Revenue Highlights

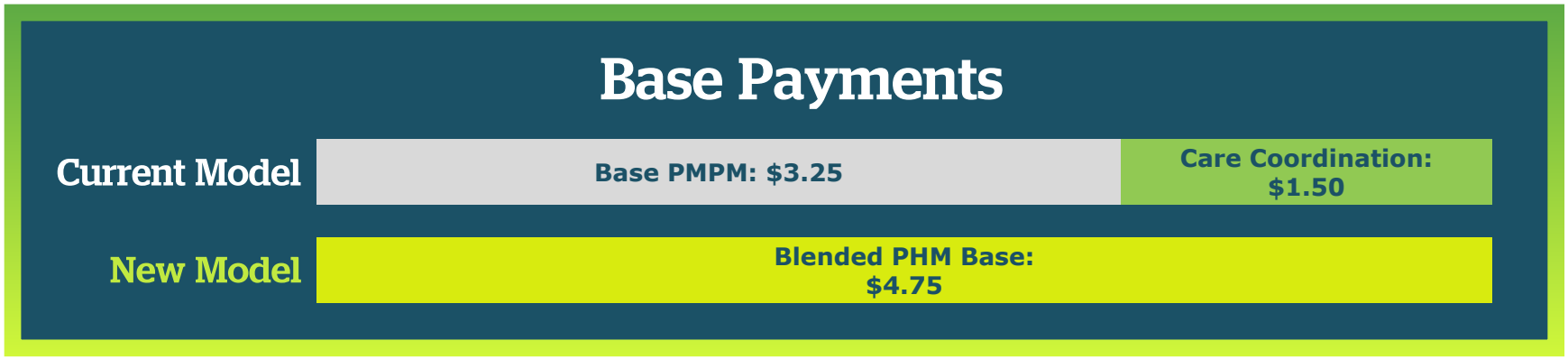
Area	2022	2023	Change
Payer Program Support	$10,460,595	$12,074,567	$1,613,972
Shared Savings (Blueprint)	$9,073,982	$9,545,916	$471,934
Fixed Payment Allocation	$3,360,439	$3,060,850	($299,589)
Other Revenues	$2,033,606	$602,206	($1,431,401)
Hospital Participation Fees	$19,623,500	$19,828,444	$204,944
Total	**$44,554,144**	**$45,114,005**	**$559,861**

Expense Highlights: Population Health Management

- Transitioning the $3.25 PMPMs, Care Coordination program funding, and VBIF funding to the new PHM model
  - Designed to sustain base payments to providers
  - Bonus potential based on quality and outcomes
  - Provides the chassis to enhance accountability in future years
- Continuing with CPR program with the $5 PMPM
  - Work has started with the CPR group to define clearer accountabilities
- Blueprint budgeted to increase by the APM trend of 5.2%
  - The decision on trend ultimately lies with the GMCB

Expense Highlights: Population Health Management Program Conversion – Primary Care

- Combines the historical $3.25 PMPM and $1.50 Care Coordination PMPM into one stream
- Maintains the same regular cash flow to primary care providers
- All else equal, this change has no impact on hospital participation fees



Expense Highlights: Population Health Management Program – DAs, AAAs, Home Health

- Consolidate prior care coordination and VBIF payments into one stream
- In alignment with the primary care model, 85% of the total pool will be paid as a base payment and 15% will be bonus opportunity
  - Same proportion that exists in 2022
  - Same measures continue through to 2023 for consistency
- In collaboration with DVHA, $500k added for MH/SUD focus
  - Specific nature of this initiative in development

CPR Program Evolution

Vision: *Link Primary Care Reimbursement through the Comprehensive Payment Reform (CPR) Program to TCOC*

Purpose:

- Create a linkage between primary care reimbursement and broader health care cost growth
- Establish a baseline to measure primary care investment levels over time

Challenges:

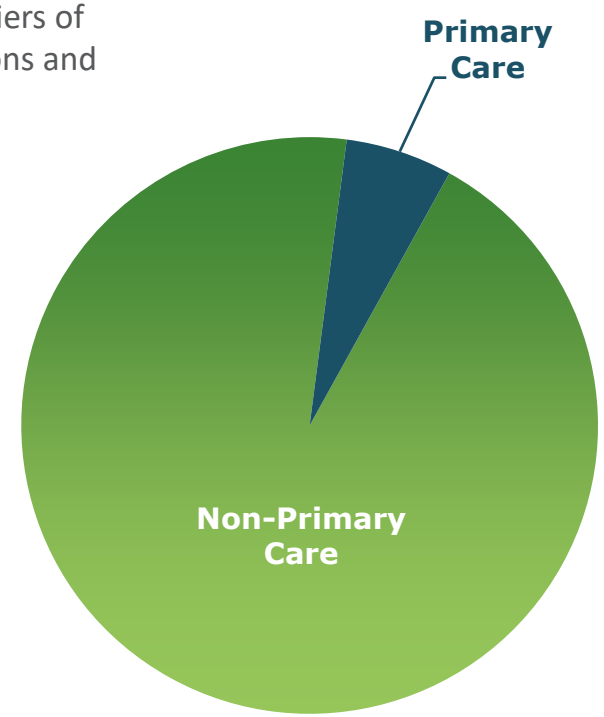
- The TCOC is a variable; makes future payment levels subject to macro-level changes
- % of TCOC works relatively cleanly within any one payer/program; is very complicated when blending payers/programs

Accountabilities:

- Providers can reach different tiers of reimbursement based on actions and outcomes which may include:
  - Mental health integration into primary care
  - Participation in ongoing program evaluation

Opportunities:

- Expand payer participation with unreconciled fixed payments
- Expansion to other types of primary care
- Continued refinement of accountabilities
- Program evaluation



2023 PHM Investment Areas

Investment Area	Amount	Focus & Purpose
PHM Program - Base	$15,274,117	Base payments intended to supply resources to engage in population health activities
PHM Program - Bonus	$2,329,915	Bonus payments tied to outcomes
CPR Program	$1,510,492	Payment reform program for independent primary care
Longitudinal Care	$399,000	Home Health benefit extension program
DULCE	$145,366	SDOH initiative with primary care and Parent Child Centers
Specialty/Innovation	$717,206	Investments in innovative program pilots with the opportunity to improve care and drive success under program goals
Blueprint	$9,545,916	Supports and Services at Home (SASH), Community Health Team (CHT), and Patient Centered Medical Home (PCMH) payments
Total	**$29,922,012**	**Total funding opportunity**

2023 PHM Investment Recipients

Provider Type	Amount	Programs
Hospital/ Hospital PCP	$10,250,510	PHM Program - Base, PHM Program - Bonus, PCMH Payments, Community Health Team Payments
Independent PCP	$5,618,833	PHM Program - Base, PHM Program - Bonus, CPR Program, PCMH Payments
FQHC	$6,143,166	PHM Program - Base, PHM Program - Bonus, PCMH Payments, Community Health Team Payments
Specialist	$185,549	Specialty/Innovation Program
Designated Agency	$1,297,403	PHM Program - Base, PHM Program - Bonus, DULCE
Home Health	$1,423,634	PHM Program - Base, PHM Program - Bonus, Longitudinal Care
Area Agency on Aging	$211,774	PHM Program - Base, PHM Program - Bonus, Longitudinal Care
SASH	$4,508,696	SASH
Other / TBD	$282,445	SNF Initiative; DULCE
Total	**$29,922,010**	

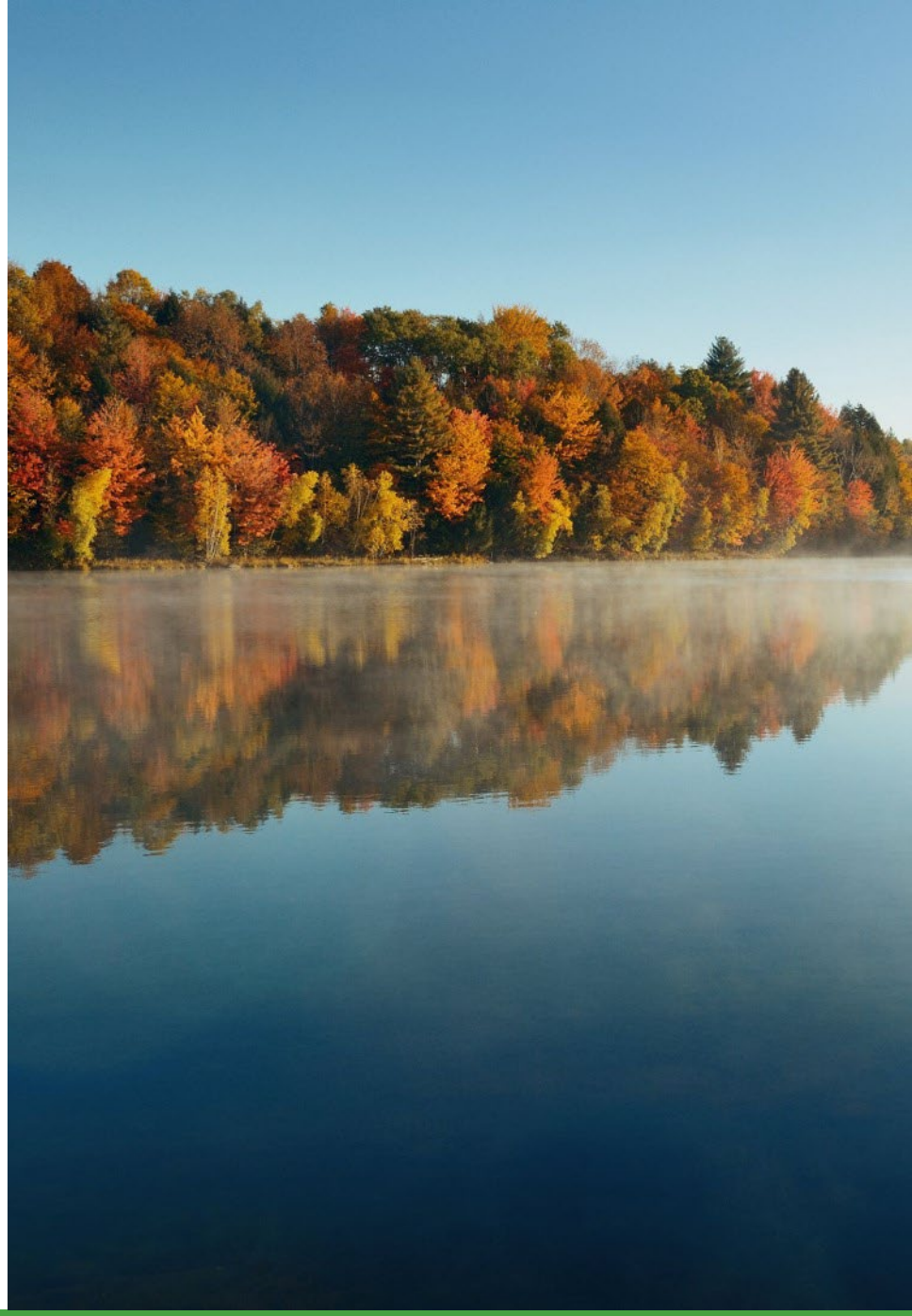
Expense Highlights: Operations

Redesign of analytics support

- Phased approach to transition to new platform and other analytics expenses (ex. software tools)
  - Net-neutral to OneCare in 2023
  - Cost model will be re-evaluated in the 2024 budget

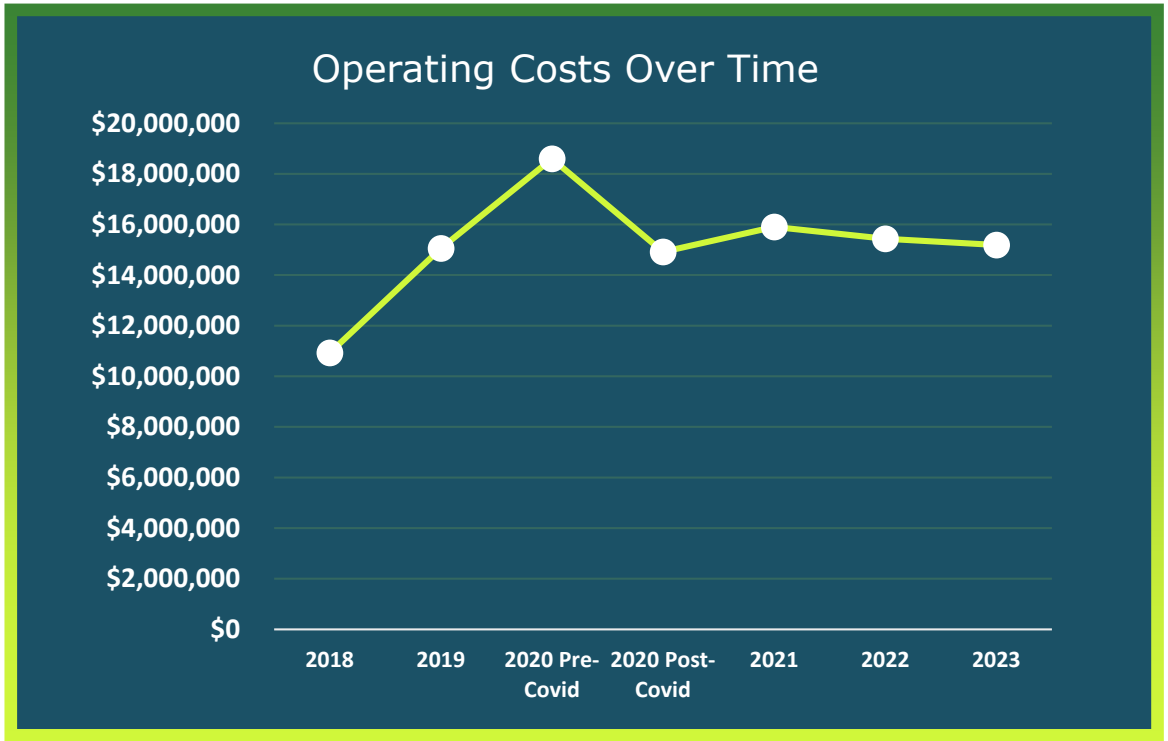
Work Reconfiguration

- Office space reduced to reflect a primarily-remote work configuration
- Other expenses reductions (ex. travel) incorporated to align with remote work



Expense Highlights: Operations

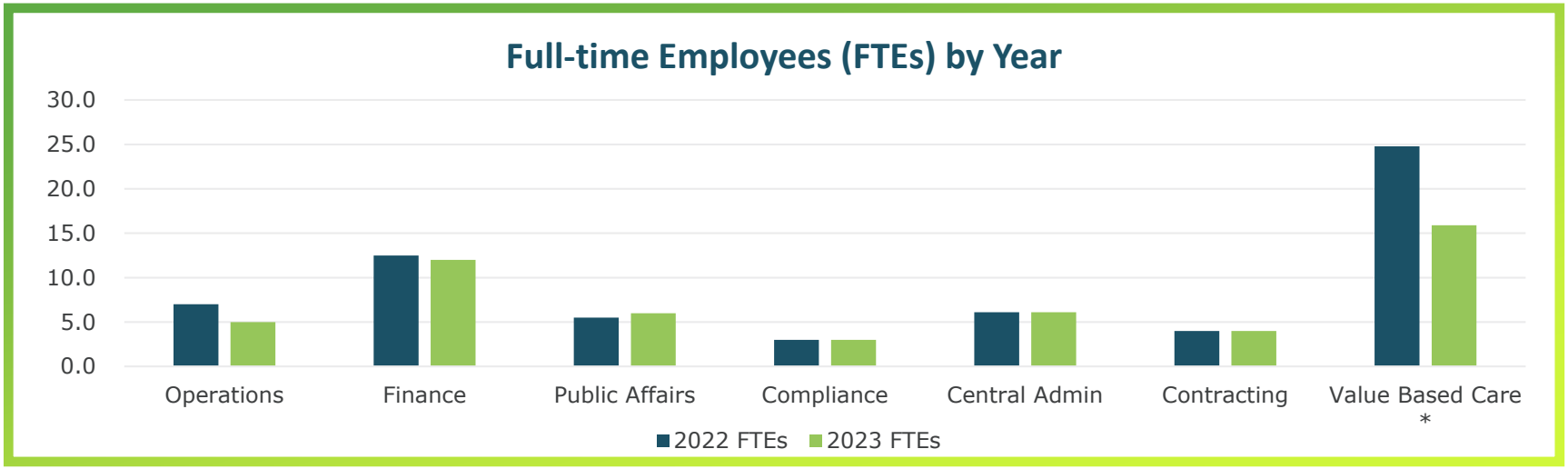
	2022	2023	Change
Salaries, Payroll Taxes & Fringe	$9,368,623	$8,704,465	($664,159)
Software/Informatics Tools	$2,683,279	$1,871,810	($811,469)
Consulting, Legal and Purchased Services	$1,366,121	$3,369,471	$2,003,350
Supplies, Travel, and Other	$2,019,514	$1,244,225	($775,289)
Total	**$15,437,538**	**$15,189,971**	**($247,567)**



- $248k expense reduction (1.6%)
- Categorical shifts due to the analytics restructuring with UVMHN
  - Net neutral to the OneCare expense budget
- $373k reduction in rent and utilities

Expense Highlights: Operations - Staffing

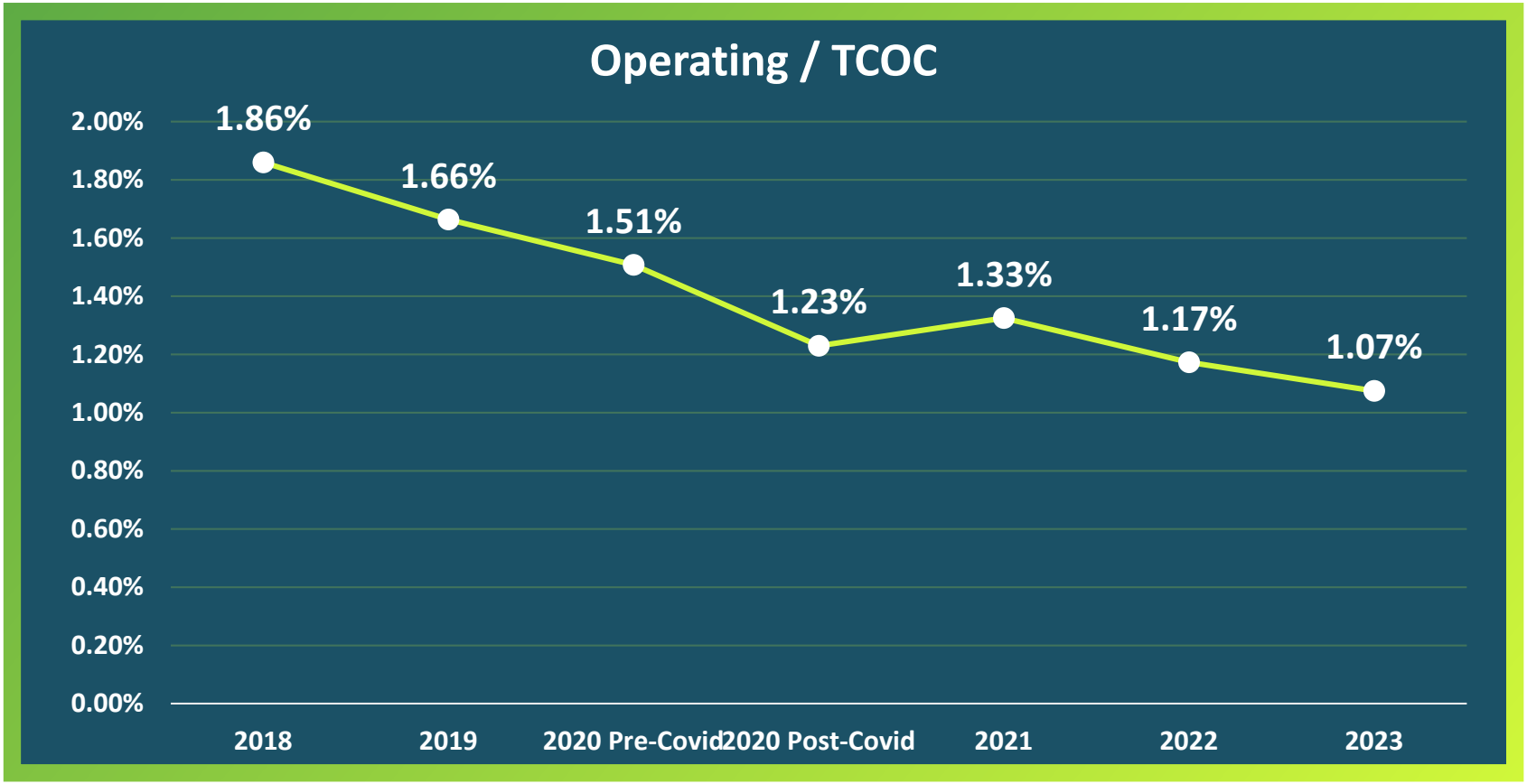
- Most significant staffing changes relate to the analytics transition to UVMHN
- Other staffing changes reflect updates based on position changes or minor organization restructuring
- Budget includes a new evaluation programs manager position to help measure the effectiveness of initiatives



	Operations	Finance	Public Affairs	Compliance	Central Admin	Contracting	Value Based Care *	Total
2023 FTEs	5.0	12.0	6.0	3.0	6.1	4.0	15.9	52.0
2022 FTEs	7.0	12.5	5.5	3.0	6.1	4.0	24.8	62.9
Change	**(2.0)**	**(0.5)**	**0.5**	**0.0**	**0.0**	**0.0**	**(8.9)**	**(10.9)**

* This Label Consolidates FTEs in Analytics, Prevention, Care Coordination, and Quality

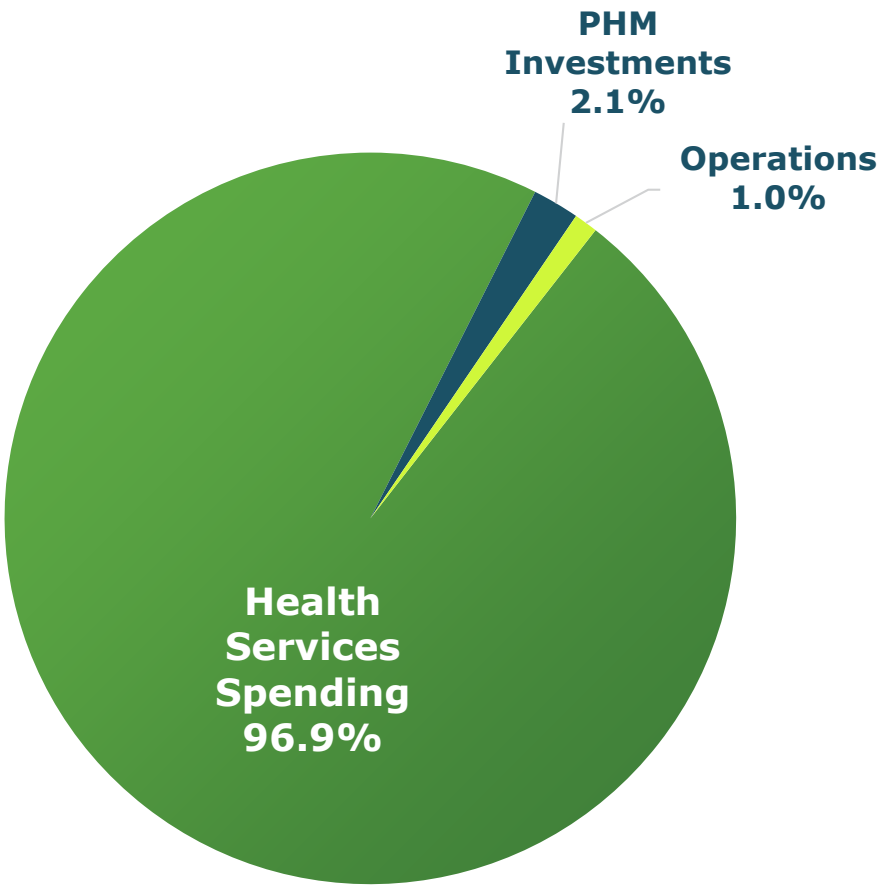
Expense Highlights: Operations



- Operating costs remain ~$15M
- Operating costs as a percentage of the TCOC continue to decline
  - Shows efficiencies of the model
- Despite efficiencies, resource demands are high

Full OneCare ACO Accountability Budget

Summary Income Statement	2023 Budget
TCOC Targets	$1,413,328,302
Payer Contract Rev.	$12,074,567
Other Revenues	$3,663,056
Hospital Participation Fees	$19,828,444
Total Revenue	**$1,448,894,369**
Health Services	$1,403,782,386
PHM Investments	$29,922,012
Operating Costs	$15,189,971
Total Expenses	**$1,448,894,369**
Gain (Loss)	**$0**



Income Statement

Revenue Category	2022 Budget	2023 Budget	Change
Medicare TCOC	$498,487,390	$552,916,537	$54,429,147
Medicare - Blueprint Obligation	$9,073,982	$9,545,916	$471,934
Medicaid - Traditional TCOC	$275,105,429	$264,095,487	($11,009,942)
Medicaid - Expanded TCOC	$44,959,054	$41,989,529	($2,969,525)
BCBSVT QHP TCOC	$141,553,837	$176,399,528	$34,845,691
MVP QHP TCOC	$64,219,054	$73,483,610	$9,264,557
BCBSVT Primary - Risk	$282,922,336	$294,897,695	$11,975,359
Self-Funded Program TCOC	$0	$0	$0
TCOC Targets Total	**$1,316,321,082**	**$1,413,328,302**	**$97,007,220**
Payer Program Support	$10,460,595	$12,074,567	$1,613,972
Fixed Payment Allocation	$3,360,439	$3,060,850	($299,589)
Other Revenues	$2,033,606	$602,206	($1,431,401)
Hospital Participation Fees	$19,623,500	$19,828,444	$204,944
Total Revenue	**$1,351,799,222**	**$1,448,894,369**	**$97,095,147**
FFS Spend	$868,279,012	$965,117,880	$96,838,868
Fixed Payment Spend	$438,968,088	$438,664,506	($303,582)
Health Services Spending Total	**$1,307,247,100**	**$1,403,782,386**	**$96,535,287**
PHM Base Payments	$0	$15,274,117	$15,274,117
PHM Bonus Potential	$0	$2,329,915	$2,329,915
Population Health Management Payment	$9,512,724	$0	($9,512,724)
Complex Care Coordination Program	$5,905,659	$0	($5,905,659)
Value-Based Incentive Fund	$1,000,000	$0	($1,000,000)
Longitudinal Care	$399,000	$399,000	$0
DULCE	$204,485	$145,366	($59,119)
CPR Program	$1,158,877	$1,510,492	$351,616
Primary Prevention	$155,000	$0	($155,000)
Specialist and Quality Reinvest.	$1,704,857	$717,206	($987,652)
SASH	$4,285,795	$4,508,696	$222,901
Blueprint PCMH	$2,062,850	$2,163,158	$100,308
Blueprint CHT	$2,725,337	$2,874,062	$148,725
Total PHM Investments	**$29,114,584**	**$29,922,012**	**$807,428**
General Operations	$15,437,538	$15,189,971	($247,567)
Risk Protection	$0	$0	$0
Total Infrastructure	**$15,437,538**	**$15,189,971**	**($247,567)**
Total Expenses	**$1,351,799,222**	**$1,448,894,369**	**$97,095,147**
Gain (Loss)	**$0**	**$0**	**$0**

Balance Sheet

	2023 Budget	2023 GAAP
Cash	$13,787,824	$13,787,824
Restricted Cash	$0	$0
Total Cash, Investments & Reserves	**$13,787,824**	**$13,787,824**
Accounts Receivable	$1,083,370	$1,083,370
Accounts Receivable from Participants - Contract Risk Settlement	$0	$0
Accounts Receivable from Payers - Contract Risk Settlement	$0	$0
Prepaid Expenses	$500,000	$500,000
Other Current Assets	$0	$0
Total Current Assets	**$15,371,194**	**$15,371,194**
Long Term Assets	$0	$0
PPE	$28,147	$28,147
Other Assets	$0	$0
Total Assets	**$15,399,341**	**$15,399,341**
Accrued Expenses/NW Payable	$5,329,915	$5,329,915
Accounts Payable to Participants, Contract Risk Settlement	$0	$0
Accounts Payable to Payers, Contract Risk Settlement	$0	$0
Unearned Revenue	$0	$0
Due to UVMMC	$3,797,493	$3,797,493
Due to DHH	$0	$0
Due to Other	$0	$0
Deferred Revenue	$0	$0
Accrued Expenses	$0	$0
Designated Risk Reserve Fund Balance	$0	$0
Debt	$0	$0
Other Current Liabilities	$585,504	$585,504
Current Liabilities	**$9,712,912**	**$9,712,912**
Long Term Liabilities	$0	$0
Other Non-Current Liabilities	$0	$0
Total Liabilities	**$9,712,912**	**$9,712,912**
Retained Earnings	$0	$0
Capital Contributions	$0	$0
OneCare Net Assets	$5,686,429	$5,686,429
Total Liabilities and Equities	**$15,399,341**	**$15,399,341**

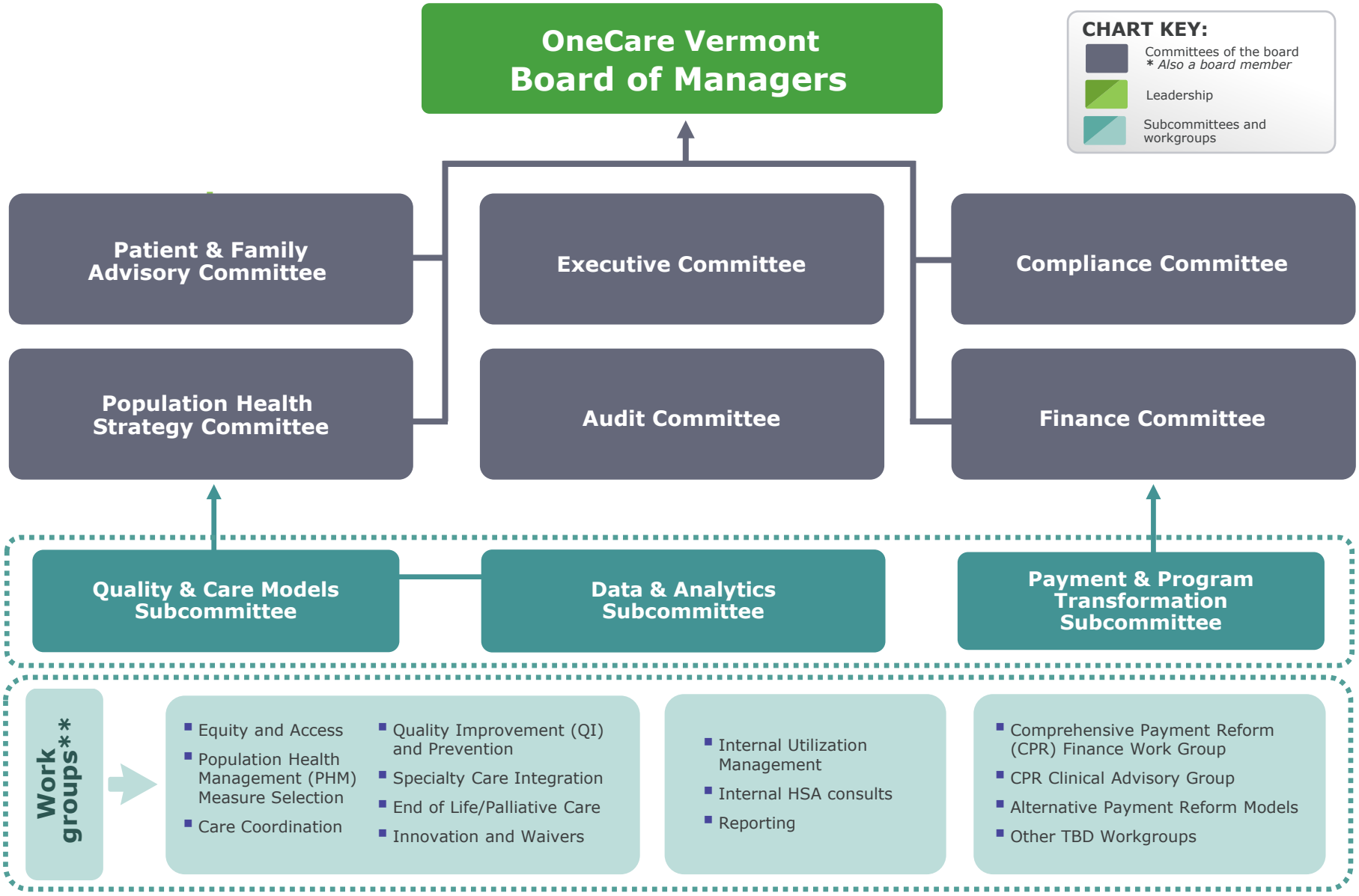
Budget Section 7

ACO Quality, Population Health, Model of Care, and Community Integration

Network Performance: Goals Set for 2022

- Reorganize our oversight and working committee structure
- Push patient panel review, management, and outreach
- Expand cross-organization connections, collaboration, and communication (starting with our committee structure) to increase inclusion and focus
- Invest in ongoing process and quality improvement
- Redesign and extend our Care Coordination requirements

OneCare Vermont Committee Structure



**Most workgroups are fluid and will form and end based on board needs.

Last updated: Thursday, September 16, 2022

ACO Committee Participation and Engagement

- Active participation
- Workgroup accomplishments
  - measure selection
  - disparities scorecard
  - prevention topics
  - care coordination activities
  - CPR developments
- Inclusive membership
- Patient and Family Advisory Council

Health Service Area (HSA) Consultation Reformatting

New approach

Ongoing coaching and support

Expanded participation

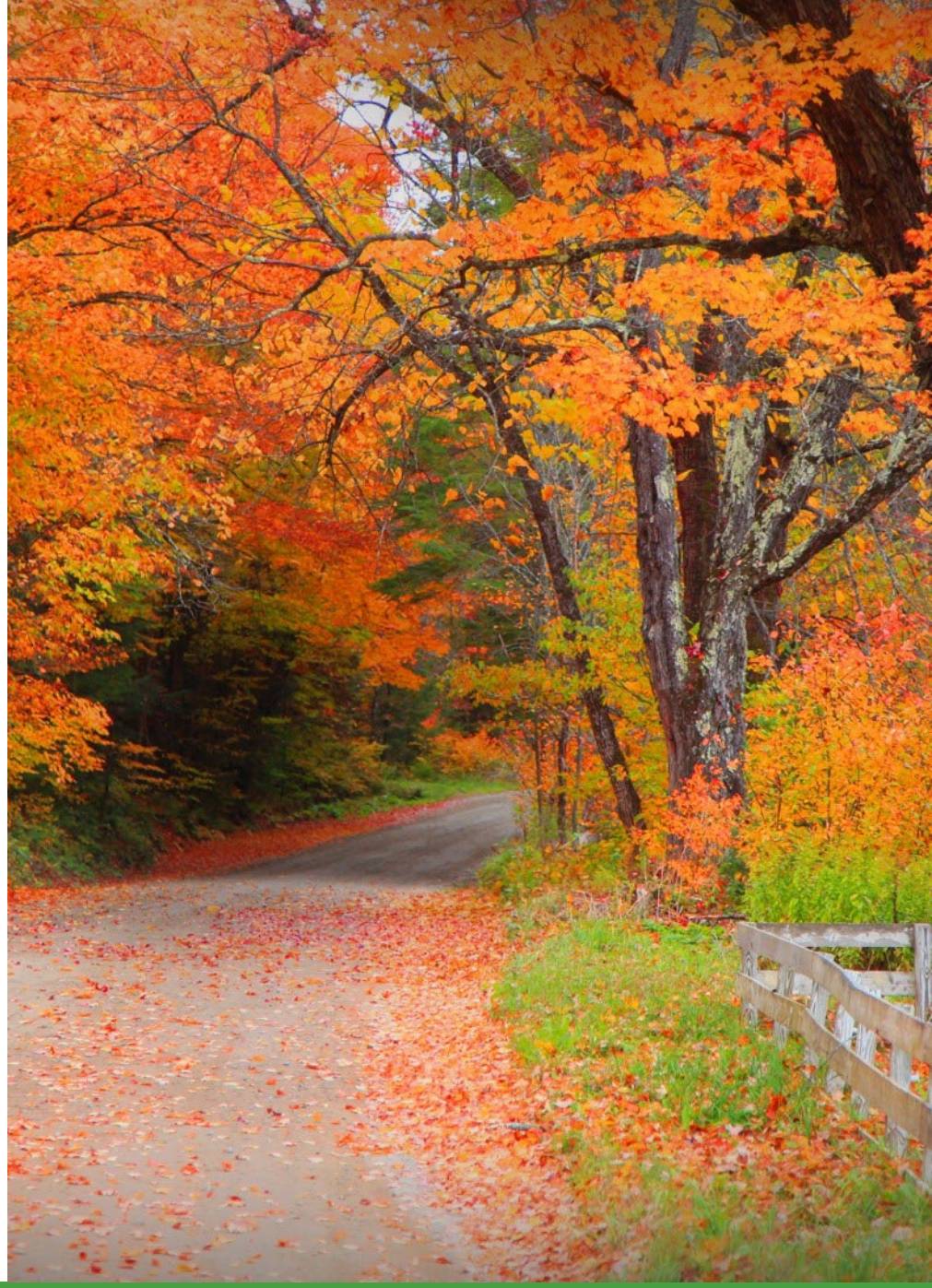
Advancing the PHM Framework

2023 Population Health Model (PHM)

- Evolving value-based payments
- Care Coordination participation required to unlock all funds
- Increasing accountability year-over-year (2023-2025)
- Pushing quality improvement
- Encouraging collaboration within the continuum of care of the HSA ecosystem

2021 Quality Results

- Strengths: 90th percentile for all payers in: diabetes control,* follow up after ED discharge for both mental health and alcohol and other drug dependence, child and adolescent well care*
- Opportunities: Hypertension control,* depression screening and follow-up,* initiation and engagement of alcohol and other drug dependence
- Using these results to set goals for 2023 PHM and raise the bar on value

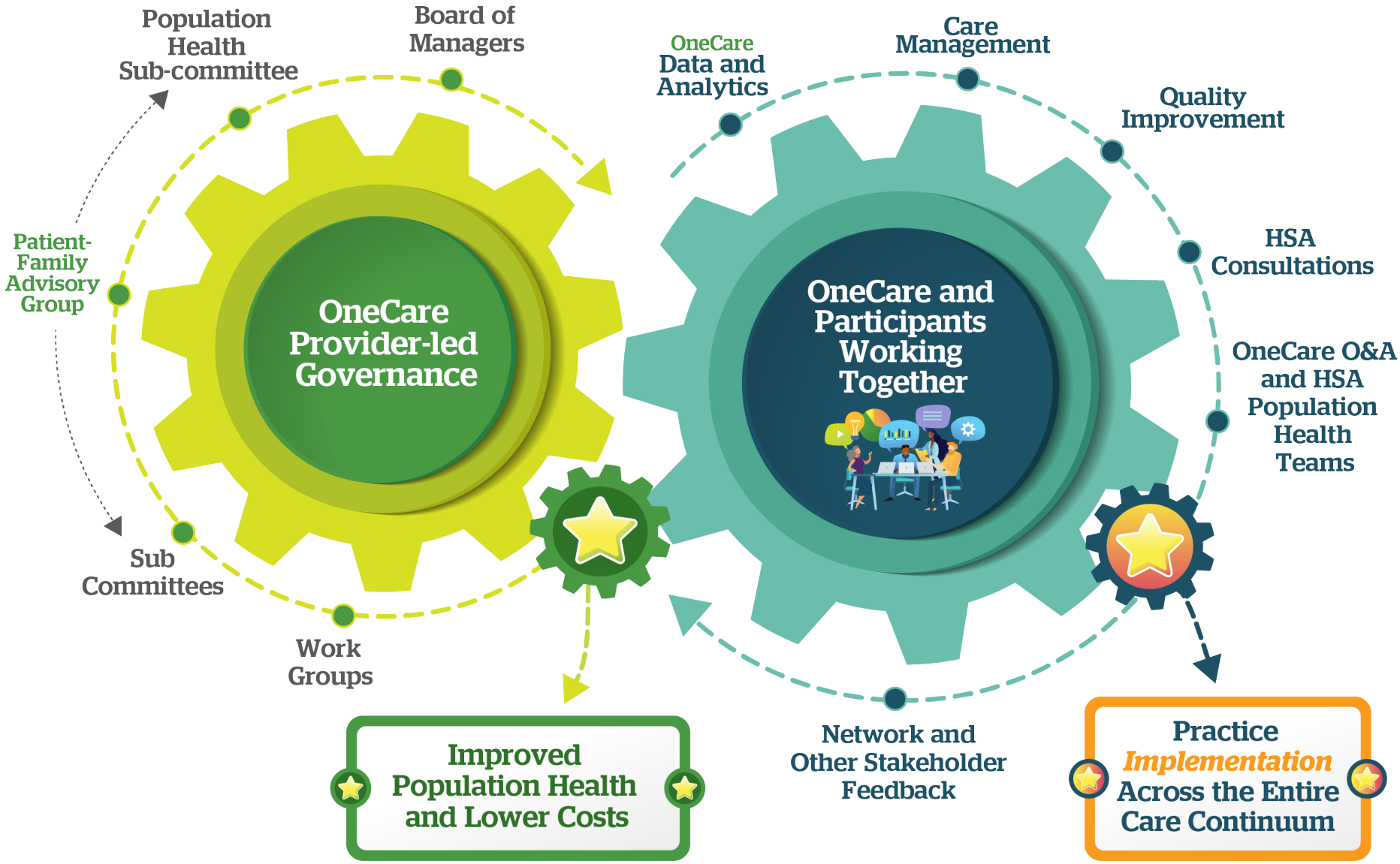


* VBIF measures

Care Coordination and Prevention Redesign

- Common threads throughout all work
- Ongoing care management of populations of focus
- Sunset of Care Navigator
- Tri-annual reporting this year and next
- Positive responses in care-managed patient survey
- Increasing HSA-wide teamwork via 2023 Population Health Model (PHM)

Population Health Model (PHM)



Budget Section 8

Evaluation and Performance Benchmarking

Key 2022 Evaluative Activities

- Examined care coordination program → evolved PHM for 2023
- Evaluated quality opportunities → informed selection of PHM metrics for 2023
- Engaged UVM health services research team to develop:
  - 10+ Key Performance Indicators (KPIs) across five domains of cost and utilization, access, outcomes, low value care, and provider engagement
  - Provider satisfaction survey; piloted with 78 primary care providers in 14 HSAs
- Conducted Medicare benchmarking analysis:
  - Compare key cost, utilization, and quality metrics to benchmarks from a peer ACO cohort (N=20 ACOs)
  - 2019-2021 Medicare populations using 100% of the national Medicare FFS data set (Parts A, B, & D)
  - Utilization and cost metrics were risk adjusted and unit costs were normalized
- Comprehensive Payment Reform (CPR) program qualitative evaluation

Early Signals from Evaluation

Strengths

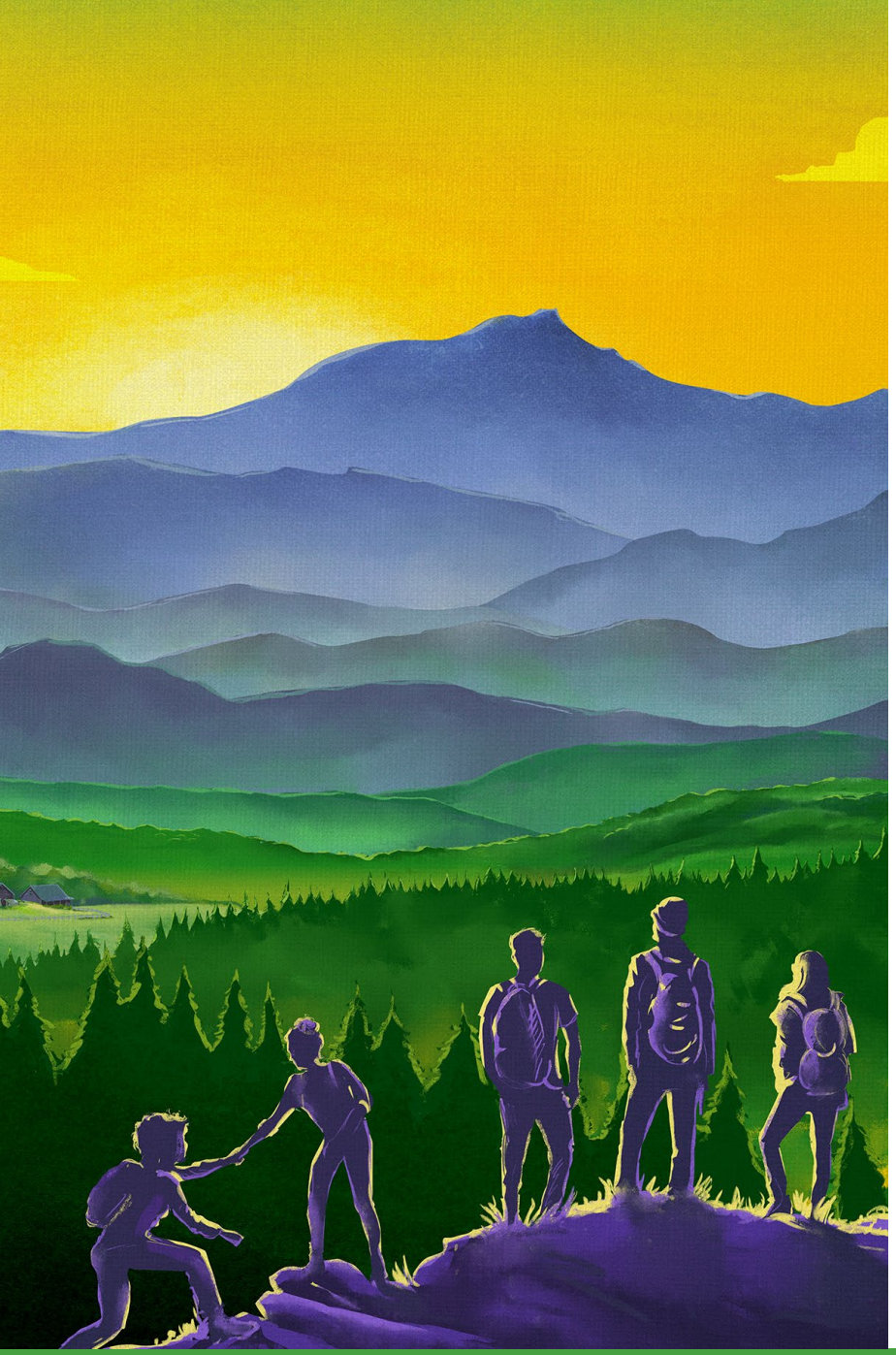
- OneCare is lower cost than peer ACOs nationally
- Preference Sensitive Admissions are low
- Pilot survey data indicate that independent primary care providers reported feeling that:
  - *OneCare supports critical aspects of their jobs,*
  - *Their job would be more difficult without OneCare, and*
  - *Quality of care delivery is improved through participation in OneCare*
- CPR program serves patients and providers better than fee-for-service model (e.g. flexibility, predictability, enhanced payments)

Opportunities

- Reduce high emergency department utilization
- Maximize role of primary care
- Optimize post acute care transitions
- Advance provider education to improve general ACO understanding

Evaluation: Next Steps

- Integrate KPIs with Medicare benchmarking reports
- Gather KPI data across payers
- Expand provider survey to other network segments
- Roll out benchmarking and survey information to OneCare Network
- Conduct further CPR evaluation
- Inform strategic plan refresh
- Hire program evaluator



Our Commitment

- OneCare's 2023 budgeted programs, investments, and operational structure advance our mission by focusing on our core capabilities:
  - *Network Performance Management*
  - *Data and Analytics*
  - *Payment Reform*
- OneCare and its provider partners are creating a new model where providers are supported to deliver the best care, at the right time, and the right place.